STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505070	A. BUILDING _____ B. WING _____	C 10/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RICHLAND	44 GOETHALS DRIVE RICHLAND, WA 99352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced complaint investigation conducted at Life Care Center of Richland on 10/09/2013. A sample of five residents was selected from a census of 78 residents. The sample included five former and/or discharged resident. The investigation was conducted by: [redacted] R.N. The investigator is from: Department of Social & Health Services Aging and Long Term Support Administration Residential Care Services, District 1 Unit C 3611 River Road, Suite 200 Yakima, WA 98902 Telephone (509) 225-2800 Fax (509) 574-5597 Residential Care Services Date	F 000	F 204 Discharge planning 1. Resident #1 no longer resides in the facility. 2. Residents are at risk for this failed practice and Staff Member B, Staff Member C and licensed nurses have been educated on discharge planning including family notification/support, arrangements for home health and /or nursing care. 3. Licensed nurses have been educated on discharge planning including family notification/support, arrangements for home health and /or nursing care. 4. The Interdisciplinary Management Team has initiated weekly discharge meetings to discuss discharge planning including family notification/support, arrangements for home health and /or nursing care needs. 5. Social Services will audit discharges to include family notification/support, arrangements for home health and/or nursing care needs. 6. Findings from the audits will be reviewed at PI times 3 months and as needed going forward. 7. ED/DNS to ensure compliance 8. Date of compliance November 8, 2013.	
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 204		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 204	Continued From page 1 to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a safe and orderly transfer for one of five residents (#1) in the sample. This failure resulted in the resident discharging to her own home without family notification/support, without arrangements for home health and/or nursing care for her indwelling catheter thus placing her at risk for potential harm. Findings included: Resident #1. The resident had multiple diagnoses including general muscle weakness, difficulty walking, arthritis, and poor vision. Additionally, she had an indwelling catheter. She used an electric wheelchair for most of her locomotion. Progress notes, dated 08/22/2013 through 08/31/2013 (the day of her discharge), documented the resident had been alert and oriented but had an ongoing presence of mild confusion. Interviewed on 10/09/2013 the resident stated she admitted to the facility (Facility A) on [redacted]/2013 for rehabilitation and intended to stay only as long as it took to switch her insurance to a provider that allowed her to transfer to Facility B, located next to her apartment, to continue rehabilitation. She stated her insurance coverage	F 204		

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F 204	Continued From page 2 ended at the facility on [redacted]/2013, a Saturday, and she had been, "panicking" because she couldn't pay for her care on her own. She had not heard from her family as the weekend started and she had not heard from the facility staff stating anything about when she was moving to Facility B, so she took matters into her hands. The resident stated she went to the nurse on duty on 08/29/2013 and told her she was moving to Facility B on the 08/31/2013 as that was the day her insurance was being transferred. "They arranged the ride for me so I got ready." Then, two days later, on 08/31/2013 she went to a different nurse on duty and told her she was leaving that day when her ride arrived. That nurse assisted her to leave the facility. On 10/09/2013 the facility's social services director, Staff Member A, stated she would normally plan all discharges from the facility and typically they were not weekend discharges. The resident's family had been working with her on a planned discharge and the process was moving forward; however, it had not been planned for 08/31/2013. It had been tentatively set for the following week; Facility B had been working with her on a date. She stated the resident had been involved in the process. Staff Member A had been out of the facility on 08/29/2013 through the long weekend and had not been made aware of the resident planning her own transportation to Facility B on 08/31/2013. On 10/09/2013, a Licensed Nurse, Staff Member B stated she had been told by the resident on 08/29/2013 of the need for transportation and had arranged the ride for her. She stated she knew the resident and her family and been working on	F 204		

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F 204	Continued From page 3	F 204		

a discharge so when the resident asked her to arrange the ride and the resident said she would pay for it she went ahead and called to make the arrangements.

On 10/09/2013, a Licensed Nurse, Staff Member C stated, "we don't typically discharge residents on the weekends, so when (resident name) came up to me first thing on Sunday morning and said she was leaving that day I tried to get everything ready as fast as I could." The doctor happened to be here, so, "I told him she was leaving." There were no discharge documents. "I had to fill them all out myself, that ' s not usually how we do it." "I think I must have called (Facility B) but I can't remember." (The staff member searched in the residents chart and could not find documentation of any phone communication to Facility B on that day). She stated she had tried to contact the family member that day but, "didn't get an answer from her."

On 10/09/2013 Facility B ' s representative stated they had not planned to admit and there were no doctor ' s orders to admit. They talked with the driver after the resident arrived and told him to take her back to Facility A.

The resident stated she directed the driver to take her to her apartment and not back to the facility (Facility A). When she arrived at her apartment she was locked out and had to wait approximately one and half hours for the maintenance man to let her in. Additionally, she stated she had called 911 to assist her in emptying her catheter bag as she had no idea how to manage it on her own. Fortunately, she had prescribed medications, including pain medications, at home.

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F 204	Continued From page 4 The facility failed to ensure the resident had a safe and coordinated discharge. This failure placed the resident at the potential for harm due to the potential for pain, bladder/kidney infection and potential harm for falls secondary to her general weakness and need for rehabilitation.	F 204		